



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEMORIAL MRI & DIAGNOSTIC

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-15-0285-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

SEPTEMBER 18, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have provided all documentation and proof for the claim showing timely filing. We were given approval on these basis so the procedure was completed. We ask that you review our submission."

Amount in Dispute: \$1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2014	CPT Code 76856 Pelvic Ultrasound	\$550.00	\$161.16
	CPT Code 76830-59 Transvaginal Ultrasound	\$450.00	\$200.06
TOTAL		\$1,000.00	\$361.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, 33 *Texas Register* 364, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin

representative box, which was acknowledged received on September 26, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Does the documentation support billed services? Is the requestor entitled to additional reimbursement?

Findings

According to the submitted explanation of benefits, the respondent denied reimbursement for the Ultrasounds based upon reason code "16."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

On the disputed date of service the requestor billed CPT codes 76856 and 76830-59.

- CPT code 76856 is defined as "Ultrasound, pelvic (nonobstetric), real time with image documentation; complete."
- CPT code 76830 is defined as "Ultrasound, transvaginal."
- Modifier 59 –Distinct Procedural Service is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

A review of the submitted reports supports billed services; therefore, the respondent's denial based upon reason code "16" is not supported. As a result, reimbursement is recommended.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2014 DWC conversion factor for this service is 55.75

The Medicare Conversion Factor is 35.8228

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77024, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

CPT code 78656 has a multiple procedure payment status indicator of "4". Per CMS Publication 100-20, Transmittal 694, effective May 7, 2010, "Medicare currently applies a multiple procedure payment reduction (MPPR) of 25 percent to the technical component (TC) of certain diagnostic imaging procedures. The reduction applies to TC only services, and the TC portion of global services, for the procedures with a multiple surgery value of '4' in the Medicare Fee Schedule database."

Medicare Learning Network Number SE0665 updated on October 10, 2012, states "A 25 percent reduction in the technical component (TC) payment for additional imaging procedures (furnished on contiguous body parts during the same session"

These policies direct a reduction of 25% on the TC portion for code 78656.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	MAR	Total Insurance Carrier Paid	Total Due
76856	75% of \$91.33 + 100% of \$35.06	\$1.16	\$0.00	\$161.16
76830	\$128.55	\$200.06	\$0.00	\$200.06

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$361.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$361.22 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

03/25/2015

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.